CONFIDENTIAL MEDICAL CERTIFICATE (LIVING ASSURANCE)

Great Eastern

Policy No. / *No. Polisi*
Policy No. / *No. Polisi*
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New NRIC No. / *No. KP Baru* - -

Old NRIC/BC/Passport No. / *No. KP Lama/Sijil Kelahiran/Paspot*

Name of Life Assured / *Nama Hayat yang Diasuranskan* ____________________

Issued by: Date:

* TO BE COMPLETED BY THE MEDICAL ATTENDANT
(IF THERE IS A CHARGE FOR COMPLETION OF THIS FORM IT IS THE RESPONSIBILITY OF THE CLAIMANT)

Claims Condition Suffered (Please tick (/) where applicable)

- ☐ Kidney Failure
- ☐ Fulminant Hepatitis
- ☐ Major Organ Transplant
- ☐ Paralysis (Paraplegia, Tetraplegia)
- ☐ Multiple Sclerosis
- ☐ Pulmonary Hypertension
- ☐ Total Permanent Blindness
- ☐ Heart Valve Surgery
- ☐ Total Permanent Deafness
- ☐ Aorta Surgery
- ☐ Loss of Speech
- ☐ Alzheimer's Disease
- ☐ Major Burns
- ☐ Coma
- ☐ Terminal Illness
- ☐ Motor Neurone Disease
- ☐ HIV Infection From Blood Transfusion
- ☐ Parkinson's Disease
- ☐ End Stage Liver Disease
- ☐ End Stage Lung Disease
- ☐ Aplastic Anaemia
- ☐ Muscular Dystrophy
- ☐ Benign Brain Tumour
- ☐ Encephalitis
- ☐ Poliomyelitis
- ☐ Brain Surgery
- ☐ Bacterial Meningitis
- ☐ Apallic Syndrome
- ☐ AIDS Cover of Medical Staff
- ☐ Full Blown AIDS
- ☐ Accidental Head Injury Resulting in Major Head Trauma

1. General Information

(a) Are you the Life Assured's usual medical physician? ☐ Yes ☐ No

If yes, over what period do your records extend? ____________________

(b) When were you first consulted for this illness? ____________________

(c) Did you inform the patient of your diagnosis? ☐ Yes, when ____________ ☐ No

(d) Is there anything in the Life Assured's family history which would have increased the risk of this illness?

____

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(e) Name and address of Doctor who referred the patient to you in connection with the condition.

Name	Address

2. Details of the Life Assured's Illness.

(a) Description of condition, cause and diagnosis. Please provide full and exact details of the diagnosis.

Condition of Illness	Cause of Illness	Diagnosis of Illness

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(b) To the best of your knowledge when did these symptoms first appear and what was the date of first consultation. Please provide a full history of the condition.

(c) What are the tests that were performed that confirmed the diagnosis? Please enclose copies of all reports, X-rays, any other imaging studies, laboratory evidence and any relevant hospital reports that are available.

(d) Please describe the nature of treatment and medication prescribed.

(e) Has the patient suffered or been treated for any chronic sickness or diseases other than this critical illness? If yes, please give full details.

(f) What is the current condition of the Life Assured and what is the prognosis?

(g) Are you completing any other forms regarding this patient for anyone else, including other insurance companies? If yes, please give details.

(h) Any further information which in your opinion will assist us in assessing this claim.

DECLARATION

I hereby certify that I have examined the above claimant and that I have answered the above questions to the best of my knowledge and belief.

Name, Address and Official Stamp

Signature

Date